

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

163-041967

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10750

FILED NOV 7 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b

OR TOWN

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

c. CITY

OR TOWN

d. STREET ADDRESS

(If outside, give location)

Yes ☒ No ☐

Inside Limits

Yes ☐ No ☒

Reside on Farm

Yes ☒ No ☐

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

DATE OF DEATH

Month

Day

Year

5. SEX

MALE

6. COLOR OR RACE

White

7. Married

Never Married ☒

Widowed ☐

8. DATE OF BIRTH

8/11/1899

9. AGE (last birthday)

64 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RESTAURANT

11. KIND OF BUSINESS OR INDUSTRY

Laborer

12. BIRTHPLACE (City and state or country)

Washington Co. Mo.

13. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Sheet Rodriguez

13b. MOTHER'S MAIDEN NAME

Luy Spire

14. NAME OF HUSBAND OR WIFE

Alice Rodriguez

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give year or dates of service)

NO

16. SOCIAL SECURITY NO.

WIFE

17. INFORMANT

Address

Rd. 1, DeSoto Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Subpharyngeal Abscess & Septicemia

DUE TO (b)

Suspected CVA, & Myocardial INFARCT

DUE TO (c)

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

20b. SUICIDE

☐

20c. HOMICIDE

☐

20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20e. TIME OF INJURY

Hour a.m. p.m.

20f. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Month, Day, Year

20g. INJURY OCCURRED WHILE AT WORK ☐

NOT WHILE AT WORK ☐

20h. CITY, TOWN, OR LOCATION

COUNTY

20i. STATE

STATE

21. I attended the deceased from

10/9/63 to 10/21/63

21. and last saw her

him alive on 10/27/63

21. Death occurred at

2:30 AM

21. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

J. E. Codd M.D.

22b. ADDRESS

German N. Lodge Hospital

22c. DATE SIGNED

10/28/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

10/31/63

23c. NAME OF CEMETERY OR CREMATORY

CATHOLIC

23d. LOCATION (City, town, or county)

HERCULANEUM, MO

23e. STATE

STATE

24. FUNERAL DIRECTOR

MAHN Funeral Home

24. ADDRESS

DeSoto, MO

25. DATE RECD. BY LOCAL REG.

OCT 30 1963

26. REGISTRAR'S SIGNATURE

Roan Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO.

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

VS 300

Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Frederick J. Mehr*
Licensed Embalmer No. 4975
P. O. Address *De Soto, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.